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The Commonwealth of Massachusetts

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To: Senior Staff
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From: Edward M. Murphy, Commissioner
Henry Tones, Ph.D., Deputy Commissioner for Mental Health

Date: April 28, 1988

Subject: Section 5 of Chapter 1 of the Acts of 1988 Plan
Civil Patients at Bridgewater State Hospital

GOVERNMENT DOCUMENTS
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Attached for your information and consideration is a copy of the Bridgewater Plan submitted to the Committees on Ways and Means. The Plan responds to widespread concern about services for mentally ill persons who act violently (or are at risk of acting violently) in inpatient settings.

The issue of preventing, managing, and treating instances of violent behavior committed by mentally ill persons in inpatient settings is of fundamental importance to our goal of providing quality care to persons with mental illnesses. As the Department carries out its mission to serve persons with long-standing or serious mental illnesses, we must pay careful attention to the design and creation of physical and interpersonal treatment environments that effectively encourage our clients and patients to learn how to solve their problems without resorting to violence.

The Plan is based on a set of assumptions and timelines defined in Chapter 1 of the Acts of 1988. We expect that the Plan will be considered carefully by senior policymakers in the Administration and the Legislature, who may decide to modify the assumptions, timelines, and implementation plans.

We welcome your thoughts and comments as we work together to develop a comprehensive service system.

**THE PLAN AS REQUIRED BY SECTION 5 OF CHAPTER I
OF THE ACTS OF 1988**

**BY
THE COMMISSIONER OF MENTAL HEALTH**

**TO THE HOUSE AND SENATE
COMMITTEES ON WAYS AND MEANS**

**EXECUTIVE OFFICE OF HUMAN SERVICES
DEPARTMENT OF MENTAL HEALTH**

**Philip W. Johnston
Secretary**

**Edward M. Murphy
Commissioner**

April 25, 1988

PREFACE

Over the last several years, the Department of Mental Health, with the support of the Governor, the Executive Office of Human Services, and the Legislature, has taken steps to improve and expand the care offered to mentally ill persons who are involved with the justice system and/or are difficult to manage clinically. These steps include:

- 1) the establishment of the Division of Forensic Mental Health;
- 2) expansion of court clinics and forensic mental health teams;
- 3) reconfiguration and expansion of DMH services for mentally ill women at MCI Framingham;
- 4) development of two new forensic care inpatient units (and planning for a third unit), for short term evaluation and clinical care for court-involved mentally ill men and women; and
- 5) improvement in the capacity of the DMH inpatient system to manage instances of violent behavior.

Additionally, staff from the Department have contributed to the Secretary of Human Services' Bridgewater Working Group. The Department has also proposed to improve its inpatient capacity in state hospitals and community mental health centers to serve behaviorally difficult patients, and these important plans have been included in the FY '89 budget submitted by the Governor.

In response to supplemental budget requests submitted by the Governor and to concern about the Commonwealth's care of mentally ill men at Bridgewater State Hospital, on January 7, 1988, the Legislature passed Chapter 1 of the Acts of 1988. Among the provisions of this legislation is Section 5 which directs the Commissioner of Mental Health to prepare and file with the House and Senate Committees on Ways and Means a report which sets forth a plan by which the Department, by March 31, 1989, will:

- 1) stop the transfer to the Department of Correction's Bridgewater State Hospital of male patients who neither are serving a criminal sentence nor have a criminal charge pending against them nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect, and
- 2) to accept at DMH facilities all patients at Bridgewater State Hospital who were transferred from DMH facilities and who neither are serving a criminal sentence nor have a criminal charge pending against them nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect.

The Department of Mental Health proposes to develop a clinically sound program to prevent, manage, and treat inpatient violent behavior. This program will result in DMH ceasing the practice of transferring non-criminally involved patients to Bridgewater State Hospital. The Department also proposes to take responsibility for the care and treatment of non-criminally involved patients who have been transferred from DMH facilities to Bridgewater State Hospital. This report presents a plan which, given Legislative and Executive approval and priority, will permit the Department to accomplish the tasks defined in Section 5 of Chapter 1 of the Acts of 1988.

In order to provide the services mandated in Section 5 of Chapter 1 of the Acts of 1988, the Department will need to develop new secure and safe facilities, recruit, hire, and train new staff, and arrange for the transfer of patients from Bridgewater State Hospital. To do this, DMH must have early access to resources and continuing assistance from the Legislature and other Executive Departments.

In formulating this plan, the Department notes that Section 4 of Chapter 1 of the Acts of 1988 created the Governor's Special Advisory Panel on Forensic Mental Health. Among other tasks, the Governor's Special Advisory Panel is charged with making recommendations about laws and services regarding mentally ill men currently at Bridgewater State Hospital, including the patients there under Sections 7 & 8 of Chapter 123.

I. INTRODUCTION: THE CONTEXT OF THE PROPOSED CHANGES

Preventing and managing violent behavior on inpatient units in mental health facilities has been and continues to be a major and vexing concern in Massachusetts and across the country. While national data indicate that mentally ill persons, in general, are less likely to act violently than persons who are not mentally ill, some mentally ill persons, including those who are being cared for within hospitals and community mental health centers, are at greater risk at certain times for behaving violently than are other mentally ill persons. Within this population, there is a small percentage of mentally ill persons who, due to complex clinical factors, have extended periods of unprovoked violent episodes for significant periods of time.

When violent behavior occurs, action must be immediate. The person behaving violently must be stopped--safely and effectively. Care must be given to persons who are injured. Patients who witness the violence must be reassured. The patient behaving violently must be assessed: what led to the violent action at this time? what can be done to aid the patient to regain control and to maintain control of violent thoughts and impulses that he or she may have? The environment must be assessed: how safe do patients and staff feel? what can be done to help patients and staff cope with feelings

of anger, fear, sadness, uncertainty? how might a safe and stable environment be restored?

Treatment of mentally ill persons who act violently begins with careful and complete multi-disciplinary evaluation. This comprehensive evaluation should produce an individualized treatment plan, with staff and the patient learning how to intervene earlier to anticipate and prevent future violent behavior. Staff who work in clinical environments that have the philosophy and means to do treatment (work to aid patients to change and improve) develop skills that lead to clinical success. Clinical success prevents patient violence.

Consideration of the care of mentally ill patients who act violently raises many questions: How should patients be treated who have a history of serious and repeated assaults on others? What kinds of clinical interventions are effective in helping these patients gain and regain control? What kinds of services and programs are needed to decrease the risk of future violent behavior? Under what circumstances should inpatient violent actions be seen as "criminal conduct", to be dealt with through the criminal justice system? Which patients should be charged with criminal conduct after acting violently? To what extent should patients who have histories of serious and repeated violent behavior within mental health facilities be cared for together with other patients? To what extent (and for how long) should such patients be housed with other patients with similar histories?

How might questions of patient violence be incorporated into the DMH's clinical value system? How might attitudes and skills that lead to non-violent dispute resolution be encouraged and woven into the fabric of inpatient (and outpatient) clinical care? How can approaches, techniques, methods of coping that use alternatives to violence be taught throughout the mental health system?

History of Section 13 Transfers

Chapter 123 of the Massachusetts General Laws was enacted in 1971. Section 13 of Chapter 123 permits the Commissioner of Mental Health to transfer "dangerous males" to Bridgewater State Hospital. Section 13 states:

If the superintendent of any facility [of the DMH] determines that failure to retain a male resident therein in strict security would create a likelihood of serious harm by reason of mental illness and that the person's violent behavior constitutes an emergency, he may, with the consent of the commissioner, transfer the person to the Bridgewater state hospital for a period not to exceed five days. At the end of the five-day period, the person shall be returned to the



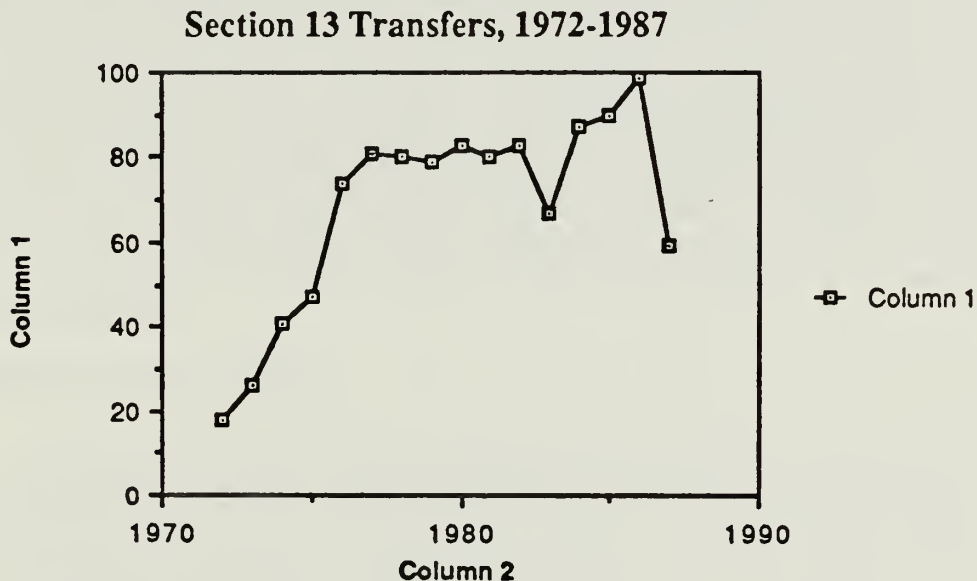
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facility unless before the end of the five-day period, the superintendent of the facility or medical director of the Bridgewater state hospital has filed a petition for his commitment to the Bridgewater state hospital under sections seven and eight.

The reformed Chapter 123 continued a legal and clinical practice that had been utilized since the nineteenth century whereby assaultive male patients were transferred to Bridgewater State Hospital from Department of Mental Health facilities.

Since 1971, the numbers of patients transferred from DMH facilities to Bridgewater State Hospital have remained quite small, varying from 18 in 1972 to 99 in 1986, and ranging from 3% to 8% of the total number of admissions to Bridgewater State Hospital each year. However, since these patients have acted extremely violently, since they tend to be the most clinically challenging in the Commonwealth, and since some patients stay at Bridgewater State Hospital per court order for many years, on any given day there may from seventy to ninety patients at Bridgewater State Hospital who originally were transferred under Section 13.



In 1976, the Department of Mental Health instituted a formal review process by which patients in DMH facilities who were seen as acutely assaultive and unmanageable were examined by senior clinical staff before a decision was made to transfer the patient to Bridgewater State Hospital. "Regional Consulting Clinicians" were appointed to work with inpatient clinical staff to insure that all reasonable clinical interventions were attempted before a transfer to Bridgewater State Hospital was approved. The Regional Consulting Clinicians meet at Bridgewater State Hospital each month with staff from Bridgewater to review the Section 13

admissions of the previous month and to work toward a more standardized state-wide system of review and practice.

While all states care for mentally ill persons who occasionally act violently while in mental health facilities, historically Massachusetts has developed services for these patients differently than most other states. Each state has a combination of special programs and facilities for short-term and long-term evaluation and care of mentally ill persons who behave violently on inpatient units. Almost all departments of mental health have either specialized facilities or programs for these patients. Very few states utilize mental health facilities operated by the Department of Correction for the care of mentally ill persons who act violently while receiving inpatient mental health care.

In Massachusetts, Chapter 123 permits three distinct categories of mentally ill persons to be sent to Bridgewater State Hospital. The first category includes men who are before the Courts after being charged with criminal offenses, but who have not yet been convicted. Men charged with crimes who are seen to be mentally ill can be sent to Bridgewater State Hospital for pre-trial evaluations concerning competence to stand trial and criminal responsibility. Men found incompetent to stand trial or not guilty by reason of mental illness can be sent to BSH for evaluation and possible commitment. The second category includes men who are in county or state correctional facilities who may be transferred to Bridgewater State Hospital by court order for evaluation if the person in charge of the correctional facility has reason to believe that the man is mentally ill. The third category includes men who are inpatients in DMH facilities, who generally have not been charged with criminal offenses and who are not awaiting trial or serving sentences, and who act so violently that they are seen as needing "strict custody."

Statement of the Problem

A comprehensive public inpatient mental health system should have the capacity to evaluate, manage, and treat the full range of clinical problems presented by persons with long-term and/or serious mental illness. Consistent with the values and support of the Administration and the Legislature, the Department, in the past two years, has taken major steps to build a system of inpatient care that is responsible for and responsive to the needs of persons with long-term or serious mental illness.

Violent behavior committed by persons who are mentally ill, while rare, is a problem of enormous concern, complexity, and cost in the community and within institutions.

Much of the ongoing effort to improve inpatient care within the DMH service system has been indirectly aimed at the goal of preventing violent behavior. Quality care results from efforts and resources that promote and provide well-run, clean, clinically designed, appropriately staffed units

with stable, responsive, trained, caring, supported line and professional staff. Quality patient care is the best prevention for inpatient violence. Violent actions on inpatient units are committed by both men and women patients. Violence by men occurs more frequently and generally results in more serious injuries than violence by women. This report focuses primarily on the behavior of male patients because, by statute, Bridgewater State Hospital has been a facility only for males.

For many years, one response to episodes of inpatient violent behavior has been to transfer a male patient who acts violently to Bridgewater State Hospital--out of the unit, out of the hospital or CMHC, and out of the DMH care system. As of March 31, 1989, if the Legislature changes Chapter 123, transfers to Bridgewater State Hospital for mentally ill men without criminal charges or criminal involvement will not be possible. What can and should DMH inpatient units do before and after March 31, 1989, to create clinically sound capacities to prevent and effectively manage patient violence?

Within DMH inpatient facilities, there are at least 400 instances a year of extreme violent behavior by mentally ill men that lead to a request for an evaluation for a possible Section 13 transfer to Bridgewater State Hospital. Violence on inpatient units has been related to many factors: noise levels, insufficient indoor and outdoor space, lack of staff, inadequate training, custodial (and not treatment) philosophy, quality of food, inappropriate psychopharmacology, boredom, lack of knowledge of how to resolve conflicts and disagreements, staff turnover and stress, lack of a sense of clinical mission and responsibility, as well as factors associated with an individual patient's psychopathology.

Fewer than one-fifth of all evaluations of mentally ill men who have acted violently on inpatient units lead to Section 13 transfers. And more than fifty percent of men transferred to Bridgewater State Hospital under Section 13 are returned to a DMH facility within one year. The mentally ill men transferred to Bridgewater State Hospital are among the most ill and disturbed in the DMH service system. The patients who remain at Bridgewater State Hospital more than one year after being transferred from DMH facilities are the most mentally ill and most difficult to manage male patients in the Commonwealth. One-third of these men have lived at BSH for more than five years consecutively, while others have spent years at Bridgewater through multiple admissions. A few of these patients have been unresponsive to a full range of modern, sophisticated, well thought-out mental health treatments, provided both by private and public sector professionals and institutions. Because Bridgewater State Hospital, historically, has not been staffed clinically or programmatically at the level necessary to provide all patients with comprehensive, individualized treatment, other men have never had the opportunity to participate in such treatment programs.

What programs, with what clinical philosophies, approaches, and strategies, with what kind of physical settings, and what kind of staffing patterns and ratios should be developed to meet the short and long-term needs of this population of patients? Where should these programs be developed? How should they be organized, administered, and evaluated? How should programs developed by March 31, 1989, fit with the overall development of comprehensive inpatient and community-based services that the Department is building for individuals with long-term and/or serious mental illness?

II. DATA GATHERING PROCESS

There were six major components of the data-gathering process for this report:

1) Clinical data were collected concerning the seventy-four (74) men at Bridgewater State Hospital during the last two weeks of January, 1988, who were at BSH following a transfer from a DMH facility. Staff from sixteen DMH inpatient facilities worked with staff from Bridgewater State Hospital to review data, interview patients, and complete Patient Profiles. Data were gathered about patients concerning:

- a) clinical history
- b) history of treatment
- c) special interventions used to control and treat violent behavior
- d) coping mechanisms that the patient uses to deal with problems
- e) highest levels of functioning
- f) activities of daily living skills
- g) relationships
- h) communication styles
- g) history of transfer between DMH facilities and Bridgewater State Hospital

2) An expert panel of mental health professionals was convened, with members who have substantial experience assessing and treating mentally ill persons who have acted violently in inpatient settings, and who are familiar with the current operations and conditions in DMH hospitals and community mental health centers. Members of the panel were interviewed concerning the prevention, intervention, and follow-up of inpatient violent incidents and what might be done in the short- and long-term to improve the capacity of DMH inpatient facilities to prevent and manage instances of violent behavior;

3) A special work group of staff from the DMH's Hospital Management Division studied levels of care for patients who either had

histories of inpatient violent behavior or were at risk of such behavior and staffing patterns for new clinical care units designed to assess and treat patients who act violently. The work group surveyed 30 states to learn about how these states care for patients who are seriously mentally ill and who have histories of acting violently while in hospitals;

4) Staff from the planning and research units of the Department analyzed data concerning patient transfers from DMH facilities to Bridgewater State Hospital and the relationship of certain clinical interventions to the use of Section 13 transfers;

5) DMH legal office staff reviewed current statutes, regulations, and policies about the evaluation and clinical management of patients in DMH facilities who are at risk of, or engage in, violent behavior;

6) engineering and hospital management staff explored the feasibility and desirability of several construction and/or rehabilitation strategies for developing new, clinically sensible units for hard-to-manage patients by January, 1989, in order to meet the March 31, 1989, Legislative deadline.

III. DATA ANALYSIS

A. Patient Profile Analysis

After a careful and lengthy process, the analysis of the patient profiles has provided the following:

- 1) the clinical complexities and psychiatric needs of each patient;
- 2) a clear understanding of the difference between patients who are transferred to Bridgewater State Hospital and who remain at Bridgewater, compared to patients on D.M.H. units who are not transferred;
- 3) an outline of a service delivery system that defines the level of care based on the patients' psychiatric needs.

Transfers

Reason for Transfer

All seventy-four patients in the profile analysis were sent to Bridgewater State Hospital for one of the following three reasons:

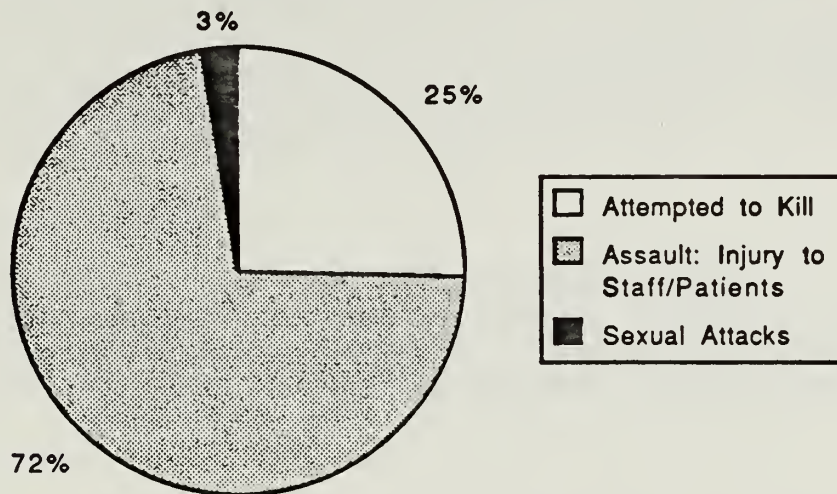
- 1) Nineteen patients, 25%, were sent to Bridgewater after attempting to kill staff or patients. These patients were extremely psychotic and responding to internal stimuli, e.g. voices, delusions. Their attacks appeared to be unprovoked acts of major violence (strangling, stabbing) that resulted in serious injury (and in one case, death).

2) Fifty-three patients, 72%, were transferred due to serious assaults that did not appear to be intended to kill but that resulted in the injury of staff and/or patients. The patients in this group were also very psychotic.

3) A third group of patients were transferred after a sexual attack on staff or patients resulting in injury: two patients, 3%, were sent for this reason.

Section 13

Reason for Transfer to Bridgewater State Hospital



Total: 74 Patients at Bridgewater State Hospital

Length of Time at Bridgewater State Hospital

1) Of the seventy-four patients, twenty-nine (39%) had been at Bridgewater for one year or less. Twenty-six of these twenty-nine had been at Bridgewater before. Only three men had not previously been at Bridgewater.

2) Twenty of the seventy-four men (27%) had been at Bridgewater between one and five years consecutively.

3) Twenty-five of the patients (34%) had been at Bridgewater State Hospital for five or more consecutive years.

Clinical Overview

The patient profiles revealed that all of the seventy-four patients were seriously mentally ill. Most remain grossly psychotic and act violently due to their mental illness. All of these patients have been mentally ill for all of their adult years. Seventy-one (96%) have histories of multiple violent

assaults. A significant number, thirty patients (40%), were diagnosed as having an neurological or neuropsychiatric component to their illness.

Treatment Response

Sixty-nine of these patients (93%) are reported to have responded only minimally, if at all, to the treatment that has been offered them. Each of the seventy-four patients was taking psychiatric medication, but medication appeared to only offer partial relief from the symptoms of their mental illnesses. The seventy-four patients generally had extraordinary difficulty tolerating interpersonal psychiatric therapies. Ten patients (14%) were reported to have intermittent individual or group therapies. Most of these patients generally could not tolerate even a short individual meeting. Current, clinically sound approaches such as rehabilitation, behavioral, or functional life skills training had not been tried.

Functional Capacity

All of the patients were assessed in the following areas: communication, self care skills (washing, shaving, toileting etc), level of activity, and relationships. This assessment revealed that the majority of patients have severe limitations in their minimal functioning capacity.

Communication:

- 15% without prompting, could state their needs, recognize a familiar person, answer a concrete question, and respond to a simple request;
- 58% were unable to either state their needs independently, answer questions, or respond to simple requests;
- 27% had limited ability to do any of the above.

Self Care Skills:

- 50% were able to maintain their hygiene and demonstrated self care skills;
- 38% needed assistance or verbal directions to complete necessary tasks: constant prompting was needed and non-compliance was a frequent factor;
- 12% were unable to demonstrate minimal self care skills.

Activities: treatment, programs, work:

- 11% participated in some activity: the average length was less than one hour a day;
- 30% participated in an activity at least one time a week;
- 59% were not involved in any structured activity.

Relationships:

- 0%** had a mutual relationship that was reported to have significant and continuing interpersonal closeness;
- 46%** had minimal or limited ability to interact with staff or peers;
- 54%** had negligible skill/ tolerance in human interactions.

Emergencies: Use of Special Interventions

The seventy-four patients studied have histories of extreme and extraordinary violence. Data gathered on emergencies and special interventions were limited to the use of seclusion. The average length of stay in seclusion for thirty-three of the patients (45%) was one day (24 hours) several times a month. But forty-eight patients (65%) required extended periods of seclusion (consecutive days or weeks at a time). These patients ranged from eight whose history revealed years of frequent and sustained use of seclusion due to their unpredictable assaultive behavior, to some twenty patients who have serious violent episodes several times a year.

General Conclusions from Clinical Data

All seventy-four patients were seriously mentally ill, with varying extremes of psychosis, and had long histories of acting violently due to their illness. Only three patients had responded significantly to the treatments offered them. All of the patients demonstrated some limitations in their abilities to communicate, use self care skills, maintain a minimal amount of meaningful activity, and interact appropriately with other people. Responses to patient violence/emergencies have primarily entailed seclusion.

The clinical staff at Bridgewater and D.M.H. were asked to list aspects of Bridgewater that had affected each patient. Staff reported that Bridgewater State Hospital is a consistent, controlled, environment where they had not been able to engage patients in comprehensive psychiatric treatment. Many patients were reported to spend much time withdrawn into psychosis. The lack of expectation and opportunity for patients to participate in comprehensive, individualized treatment programs appears to have decreased patient violence, but has not provided opportunity for significant growth or recovery for these patients. Almost all staff said that there was serious need to provide increased treatment and programs to teach and empower patients to find and use alternatives to violence and to increase their abilities to function.

B. Levels of Care:

A Continuum of Clinical Services Based on Needs

From the analysis of the Patient Profiles, the psychiatric needs of the seventy-four patients studied were evaluated. Using this information, a

"Level of Care Continuum" was developed in an effort to begin to devise a clinically appropriate, well planned service system for these very disturbed patients. The "Level of Care Continuum" has two general categories and five subdivisions, starting with the most clinically complex patients and progressing to those patients who have shown some response to treatment and could possibly join the current D.M.H. hospital system after one year of specialized intervention.

LEVELS OF CARE

INTENSIVE CARE:

Intensive Long-term
Intensive Short-term

EXTENDED CARE:

Extended Acute
Extended Long-term
Extended Transitional

Intensive Care

This category has two levels of care for patients presenting both an ongoing psychiatric emergency and an imminent danger of serious physical harm. These patients need a high degree of emergency psychiatric care with a strong emphasis on psychopharmacology, neuropsychiatry, and behavioral analysis, and individualized treatment planning.

1. Intensive Long-term:

This category includes eight patients who are grossly psychotic and present an imminent danger of physical assault for extended periods of time. Typically, these patients have been managed primarily in seclusion or restraint for at least several years, leaving seclusion or restraint only under intensively supervised conditions.

Intensive Long-term:

The eight patients in this group have been at Bridgewater State Hospital from four to eleven years consecutively (with an average of eight years). They have been mentally ill generally since their teens or early twenties. One patient has been cared for in state mental health or retardation facilities since he was a little child. Generally, these patients are preoccupied with voices in their heads that tell them what to do. They have been treated with a range of anti-psychotic medications and with a

variety of psychiatric interventions, but have continued to remain grossly out of contact with reality. Several of these patients hear voices that tell them to hurt themselves or to hurt others. Several patients are too disabled or disorganized to communicate to staff the thoughts and ideas that preoccupy them. These patients have histories of frequently (i.e. several times a day or week) assaulting others or injuring themselves (several times a day or a week). As a result, they spend much of their time in seclusion or restraints. When not in seclusion, staff must observe them closely, in order that they might restrain them should they attack others.

2. Intensive Short-term:

This category includes ten patients who are grossly psychotic and present an imminent danger of physical assault for limited periods, usually lasting from five days to six months.

Intensive Short-term:

These are patients who are acutely psychotic and assaultive. They often hear voices that tell them to attack others, or they believe that other persons are trying to hurt or kill them and that they must attack first. They are unable to concentrate and are easily overwhelmed by interpersonal stimulation. They misinterpret reality and are likely to attack others because they are so afraid. At the time of the data gathering effort, there were ten patients in this group. Patients in this group respond over days, weeks, and months to intensive psychiatric treatment. They experience a diminution of psychotic symptoms and are more able to respond to the requests of others.

Extended Care

This category has three levels of care for patients who are unpredictably violent and who experience acute episodes of violence at varied levels of frequency and intensity. During periods of non-violent behavior, these patients would clearly benefit from services and programs utilizing innovative treatment modalities. There would be a clear benefit from a behaviorally-trained milieu with a strong assessment capacity concerning the patient's neurological, behavioral, and psychopharmacological needs. A number of these patients could be considered for a Functional Life Skills Program which features systematic training/learning in five areas; communication, self care, progressive activity level, human interactions, and behavior (e.g. managing feelings, alternatives to violence, etc).

3. Extended Care Acute:

This category includes twenty patients who experience episodes of acute violence one time a month to several times a month. These patients are unpredictable, with nonexistent to extremely limited ability to control these episodes. In one year, typically, a patient in this group would need intensive acute care several times.

Extended Care Acute:

Patients in this category have histories of gross psychosis and related seriously assaultive behavior. Most have been mentally ill for five to fifteen years. They are continuously psychotic but are able to refrain from violent behavior for several weeks at a time. They have difficulty functioning without considerable direction, rules, and supervision. A number of these patients have histories of multiple, life-threatening, planned assaults on staff and patients, both within Bridgewater State Hospital and DMH facilities. Some appear to attack randomly, without identifiable signals preceding their violence. Some have histories of searching for objects that they can use as weapons in attacks. Staff who work with these patients are constantly aware of the potential for violence that they present. Several times a year or more, these patients go through periods in which they need intensive acute care.

4. Extended Care Long-term:

This category includes thirty patients who have been hospitalized for many years and who historically have had extreme unpredictable episodes of violence, although at a less frequent rate than persons in the previous levels of care.

Extended Care Long-term:

There are two categories of patients in this group. One set of patients has been mentally ill for many years, often with repeated hospitalizations. Their symptoms include unremitting psychotic experiences, such as continuous voices or fixed delusional ideas. When acutely psychotic or upset, they have physically injured others, sometimes quite seriously. At Bridgewater State Hospital, they function in a minimal and marginal way, but rarely attack or injure others. (One patient, for example, killed and mutilated a patient in a DMH facility in the 1970's and has remained at Bridgewater, relatively incident free, since that time.) These patients have lived interpersonally isolated from others, with severe deficits in basic life skills, for many years.

The second category of patients includes those who, while psychotic, have committed acts of major violence against persons in the community or persons in DMH facilities, and who usually remain incident free at Bridgewater State Hospital, but appear relatively well-organized. These patients often have fixed delusion systems that justify their attacking others. They generally do not act violently at Bridgewater, but have histories of planning and attacking patients and staff in DMH facilities and/or escaping from those facilities and attacking persons in the community. Patients in this group generally have little understanding of their mental illness. They tend to collect grievances and to feel unfairly treated, feelings which justify their violent actions. Some of these patients have been charged, in the past, with serious criminal offenses, but the courts ultimately dropped charges. These patients, like others, often have been mentally ill for many years, but appear better organized and less overtly psychotic than other patients who need long-term extended care.

5. Extended Care Transitional:

For these six patients, episodes of violence have decreased to perhaps less than one time every eight months and there has been some responsiveness to treatment. These patients are in need of specialized program opportunities to develop the skills necessary to return to a traditional inpatient environment.

Extended Care Transitional:

Patients in this category have histories of acute psychosis and violence, and have responded to psychiatric treatment. Often, before becoming mentally ill, they had been able to develop sets of interpersonal relationships. Their work and educational histories, generally, are more extensive than those of other patients. When acutely psychotic, these patients are likely to become suspicious, frightened, and to attack others. A number of these patients have histories of repeated admissions to DMH facilities and repeated admissions to Bridgewater State Hospital. These patients generally appear to have the capability to learn how to deal with their illness, but they have had much difficulty utilizing existing treatment opportunities at Bridgewater and in the DMH system.

C. Expert Panel Analysis of the Current Department of Mental Health Inpatient Care System: Capacity to Manage Patients who are at Bridgewater State Hospital

The current inpatient system is made up of Community Mental Health Centers and State Hospitals. Each has a varied ability to manage patients

who have acute episodes of violence due to their mental illness. An important part of the data gathering process and the planning assessment was the discussion and conclusions outlined by the **Expert Panel** which convened to provide information and perspective on the capacity of the current DMH system to provide services for the patients transferred from DMH facilities to Bridgewater State Hospital.

Historically, the Panel noted that the DMH inpatient system has suffered from decades of decay. It has only been during the past several years, beginning with the Hospital Plan and the Governor's Special Message, that there was a strong effort to begin to upgrade DMH inpatient care and custody standards. The Panel also noted that Bridgewater State Hospital was the only "back door" for the DMH inpatient system, the only alternative for patients who acted violently due to mental illness. At DMH facilities, the lack of appropriate staff, adequate staff-patient ratios, serious space deficiency, lack of professional staff, minimal training, etc. made treating any patient extremely difficult, and treating episodes of violence extraordinarily so. The recent important resources given to the inpatient system have laid the framework for the continuation of positive change, although decades of decay can not disappear in a few years, and it will take continual strong effort and thoughtful planning for the DMH inpatient system to continue its progress.

The Expert Panel noted that the DMH Capital Plan provides for the development of small, carefully designed inpatient units for special care for patients who are at risk of violent behavior. The Panel pointed out that difficulties posed by stopping Section 13 transfers in 1989 and developing new services for patients who have been transferred to Bridgewater State Hospital are exacerbated by the current crowded and physically subpar conditions that exist in many DMH facilities. These conditions are being addressed by implementation of the Governor's Special Message and the Capital Plan, but it will take several more years before major improvements are fully achieved.

The Expert Panel outlined three major factors that exist in all DMH inpatient units that make the management of violence extremely difficult.

• The first and most obvious reason is the serious building limitations. Most DMH units were, at one time, medical or surgical wards. This type of design has numerous limitations. Most hospital units have open dormitories, with only a few single rooms. Most of the units do not have space for programming and treatment, nor do they have space for quiet or seclusion rooms, both important interventions in deferring and defusing violent episodes. No current DMH inpatient units are designed to provide the security needed to prevent and manage patient violence. Overcrowding at many hospitals and CMHC's add other important debilitating dimensions to the inpatient system. The Expert Panel suggested that generally the too-high noise level on many inpatient units, lack of adequate staffing, lack of time and staff to provide treatment, and a lack of training and expertise in

the management, prevention and treatment of patients who have acute violent episodes, are all realities in the current inpatient system.

☛ The second factor outlined by the Expert Panel was the lack of an appropriate "Level of Care Continuum" for patients who are currently at Bridgewater and for patients who are in the process of entering or leaving Bridgewater. It is important to note that many patients who have been to Bridgewater State Hospital have been sent there multiple times, after repeated violent actions. There is a large void in the continuum of care for patients who are seriously mentally ill and have acute episodes of violence. The safety and security needs of these patients are typically different than those of other long-term mentally ill persons who have been cared for in state hospitals and community mental health centers.

The Panel described the movement of patients between DMH facilities and Bridgewater State Hospital in the following manner. Due to extreme violence, a patient is transferred to Bridgewater State Hospital under Chapter 123, Section 13. Often, the frequency and the magnitude of patient violence diminish because of the lack of demands and human contact and the physical structure of the environment. After a number of weeks or months at Bridgewater, a patient who has not acted violently is returned to a DMH unit where there is likely to be a high stress level due to overcrowding and other factors mentioned above. The patient's stay at Bridgewater has resulted in his "behavioral stabilization." However, he has not learned alternatives to violence; he has not learned to ask for help; he has not developed any additional internal controls. His functioning capacity, his inability to use communication, his inability to perform self care tasks, his inability to be involved in meaningful activities and his inability to tolerate a basic human interaction remain unchanged; and, while less overtly psychotic than when sent to Bridgewater, he is likely to remain psychotic.

☛ The third factor outlined by the Expert Panel is the poverty of information, knowledge, understanding and training about violence and treating patients who have extreme episodes of violent behavior. For example, each DMH inpatient unit has its own understanding of how to utilize special interpersonal interventions, seclusion and restraint, and psychopharmacological treatment, during emergency situations. Knowledge about preventing and managing violent behavior is important because the ability to respond quickly and effectively during an emergency can minimize the intensity and duration of the episode. There is a clear need to provide a spectrum of training to DMH staff, from the prevention of violence to teaching patients alternatives to violence. The Expert Panel strongly recommended enhancing the Department's ability to provide quality services by shifting from a reactive position to a proactive position on the treatment of violence.

Directions and Recommendations from the Expert Panel

1) There was a strong recommendation for the creation of a Resource Team that would be centrally located and responsible for providing training and consultation to the inpatient system concerning the treatment needs of the seriously mentally ill who have episodes of acute violence. This team would facilitate active learning and enable the inpatient system to begin to develop a solid treatment capacity.

2) The second recommendation was that a continuum of care be developed for the DMH patients at Bridgewater and the patients who have been moving back and forth between DMH and Bridgewater. The DMH should first begin treating these patients at Bridgewater. There are current state-of-the-art treatment approaches for patients who have not responded to the traditional therapies (e.g. medication, individual therapy, group therapy) which must be considered. The Expert Panel supported the development of specialized units to provide treatment where there has been a void. Finally, the Expert Panel pointed out that, despite the best of intentions, creation of a quality service system with the appropriate level of care continuum for these seriously mentally ill patients cannot be accomplished in a year's time.

D. Inpatient Service Systems in Other States for Seriously Mentally Ill Patients who Act Violently

Part of the data and information gathering process included examining other state mental health systems, focusing on the organization of services, types of programs, and quality of services for seriously mentally ill patients who act violently in inpatient settings.

Organization of Services

A telephone survey of thirty state departments of mental health was conducted. Information about the organization of mental health services was collected from all thirty states. Twenty of these thirty states, who appeared proactive and treatment oriented, were selected. Staff gathered information about the types of programs and services being offered to seriously mentally ill patients who exhibited episodic violence in inpatient settings in these states.

There are two organizational structures used by most states. The first consists of an inpatient structure with state-wide hospitals that specialize in providing services for one general level of care (e.g., acute, chronic). This organizational structure generally also includes a department of mental health maximum security hospital that serves civil and forensic patients.

The second organizational structure consists of regional Community Mental Health Centers, which provide care primarily for persons who need short-term psychiatric hospitalization, and regional State Hospitals, which provide care for acute and chronic patients. Some of the State Hospitals also have separate secure care units for patients needing short term intensive care (30 days) and secure care units for forensic evaluations. In addition, this organizational structure also included a maximum security hospital that provides care for civil and forensic patients.

Of the mental health systems surveyed, all provide care for the seriously mentally ill, including those who act violently within inpatient settings. Massachusetts is rare in having its Department of Correction provide care for seriously mentally ill patients who are not serving criminal sentences. Almost all state mental health systems have a maximum security hospital or hospital units that provide care for civil and forensic patients. During telephone interviews, mental health administrators were specifically asked about whether they separate patients who face, or have faced, criminal charges from civil patients. Typically, the response was, "We did that quite some time ago but stopped because most states do not separate these patients....Clinically the patients have, for the most part, similar service needs".

The majority of state mental health systems surveyed are responsible also for providing inpatient care for all incarcerated mentally ill persons. However, in a small but growing number of states, the department of correction provides these services. In several other states, there are joint efforts by the department of mental health and the department of correction to serve these patients.

Types of Services and Programs

Officials of a majority of the twenty states from whom information was gathered depicted a population that had not responded to traditional interventions. This population was seen as more clinically complex and challenging than other long-term mentally ill patients cared for on the other wards. It was suggested that these complexities went beyond mental illness and included a significant neuropsychiatric impairment. Assaultive patients were seen as needing more space and a less stimulating environment. Most of those surveyed indicated that a strong need exists for a structured, predictable environment that has specific mechanisms for limiting inpatient violence (for example, required relaxation). These patients also need specialized services with a sophisticated evaluation capability, particularly in psychopharmacology, neuropsychiatry/ neuropsychology, and behavioral therapy.

At present, the treatment philosophies of existing units and services vary widely, with only a few programs featuring a single discipline (strictly behavioral). Most programs combine approaches and support a process of

developing individualized treatment plans that may include a behavioral structure, along with expressive therapy and functional life skills training.

All those interviewed emphasized the importance of staff training and the need to recruit and retain highly motivated, skilled staff. The quality and consistency of staff response is seen as a critical factor in the successful operation of units and/or hospitals for patients who are at risk of acting violently.

IV. RECOMMENDATIONS:

The Department proposes a plan to take responsibility for mentally ill patients who behave violently in DMH inpatient settings and for the mentally ill patients who were transferred from DMH facilities to Bridgewater State Hospital and who neither are serving a criminal sentence nor have a criminal charge pending against them nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect. The plan, which is consistent with the Governor's Special Message and the Capital Plan for the Department, has two major components. The first component will enable the DMH to stop all transfers of non-criminally involved patients to Bridgewater State Hospital. The second component will enable DMH to effectively treat the patients who are currently at Bridgewater State Hospital and who have been there for a significant number of years due to their violent behavior.

1) Prevention, Management, and Treatment of Inpatient Violent Behavior

a) The Commissioner will develop an **educational** campaign designed to aid DMH staff and patients to learn consistently how to prevent, manage, and treat instances of patient violence. These activities will begin with the articulation of a clinical philosophy that is based on the idea that good quality mental health treatment is the best prevention of inpatient violent behavior. Care that respects patients and involves patients and staff in activities that teach non-violent ways to solve problems and to deal with conflicts is the best long-term strategy to decrease incidents of patient violence. The Commissioner's educational campaign will seek to clarify the laws and policies regarding the variety of clinical interventions that are useful in preventing and managing episodes of violent behavior. In this regard, the Department must develop clear and coherent guidelines that apply to and are understood by staff in all DMH inpatient units concerning the use of interventions such as seclusion and restraint.

b) The Department will develop the services called for in the Governor's FY '89 budget request to treat behaviorally difficult patients

residing in DMH hospitals and community mental health centers. This is a key step which will enable the Department to continue to decrease Section 13 transfers.

c) The Department will develop a **Prevention of Violence Resource Team**. The Resource Team will be composed of clinical specialists knowledgeable about mental illness and violent behavior: psychiatrists, psychologists, nurses, social workers, and an internist. The Resource Team will consult to staff in all DMH facilities. Members of the Resource Team, who will be on-call on a twenty-four hour basis, will help to develop individual treatment strategies for patients who are at risk for violent behavior and will work with unit staff to treat patients who have acted violently in inpatient settings. The Resource Team will be responsible for transferring patients from DMH inpatient settings to new Intensive Acute beds that will be developed and for aiding the transition of patients from Bridgewater State Hospital to DMH inpatient units. The Resource Team will be responsible for developing state of the art, system-wide training programs for DMH staff in the prevention, management and treatment of patient violence.

d) DMH facility managers will be offered a **menu of options** to aid them to improve each facility's capability to prevent, manage, and treat instances of inpatient violence. Options to be offered include:

i) designation of a mental health worker per inpatient unit with responsibility for developing prevention of violence programs; developing monitoring systems for patients at risk of violent behavior; coordinating care programs for patients with histories of inpatient violence; and assisting in staff training concerning the prevention, management, and treatment of inpatient violence;

ii) funds to develop a pool of "specials" (staff who can work on a 1:1 basis with patients who are at risk of acting violently and who can relieve unit staff members scheduled to participate in training);

iii) funds for inpatient climate and environment improvements, such as rugs, soundproofing, exercise equipment, and modern restraint equipment that might increase the capacity of DMH units to provide more homelike and emotionally "warmer" settings for patients, thereby decreasing the likelihood of patient violence. Specialized equipment would increase unit capacity to respond to instances of violence in clinically appropriate ways; and/or

iv) training programs for line and professional staff concerning the prevention, management, and treatment of violent behavior on inpatient settings.

2) Development of Capacity to Treat Non-Criminally Involved Patients currently at Bridgewater State Hospital who were transferred from DMH facilities under Section 13

The Department proposes to assume responsibility for all patients at Bridgewater State Hospital on March 31, 1989, who have been transferred from DMH facilities under Section 13 and who are neither serving a criminal sentence nor have a criminal charge pending against them nor are awaiting sentencing, except for persons found not guilty by reason of mental illness or mental defect. The Department proposes the following possible approaches to effectively implement this new Legislative mandate.

Plan a : Full DMH Care

The Department will develop two forty-bed facilities, one in Boston; the other at a state hospital site, to provide the five levels of care needed for these patients: Intensive Short-term, Intensive Long-term, Extended Care Acute, Extended Care Long-term, and Extended Care Transitional. These facilities will be staffed by fully-trained DMH professional and line workers to provide care and treatment to the patients.

Plan b : Full DMH Care with assistance from private psychiatric hospitals

The Department will develop two thirty-five bed facilities, one in Boston; the other at a state hospital, to provide four levels of care needed for these patients: Intensive Short-term, Extended Care Acute, Extended Care Long-term, and Extended Care Transitional. These facilities will be staffed by fully-trained DMH professional and line workers to provide care and treatment to the patients.

The Department will purchase care in private psychiatric hospitals for eight patients who need Intensive Long-term care.

Development of new, safe and secure, clinically appropriate facilities and programs for the population of patients described in this report will occur at a time of much change in the mental health system and the forensic mental health system. The Department has embarked on a process that will result in the rebuilding of the state hospital system. This effort, described in the Department's Capital Plan, is based on the premise that services will be provided in inpatient functional units in hospitals that are accredited by the Joint Commission on Accreditation of Health Care Organizations. As noted earlier, the Governor has appointed a Special Advisory Panel on Forensic Mental Health to make recommendations about facilities and services for court-involved mentally ill persons, including the patient population that is the subject of this report.

Plan c: Transitional Considerations: Partial DMH Care, with offsite assistance to the DOC

Given the many changes in the current configuration of mental health services that are occurring (or will soon occur), the Department is seriously concerned about the timing and complexity of the implementation of either of the proposals described above. In order to meet the intent of the Legislation, it may be necessary to develop transitional services. This could involve the Department in providing professional and line workers to enhance the care of patients at Bridgewater and aid them to make appropriate transitions to DMH facilities. Accordingly, the Department offers the following plan:

The Department will develop two twenty-five bed facilities and, in addition, will add inpatient capacity to the state hospitals to provide care for these eighty patients. These efforts will be consistent with the Department's Capital Plan.

During the transition, the Department will provide professional and line staff, as appropriate, to care for those patients who need intensive long-term care, extended acute care, and extended long-term care at Bridgewater State Hospital, and aid them to make gradual transitions to DMH facilities.

Costs:

The Department is working with the Executive Office of Human Services and the Executive Office of Administration and Finance to develop the cost analysis and budget data to accompany Plans a, b, and c. These data will be submitted shortly. In developing cost data, the Department has been guided by analysis of what is needed to provide quality inpatient care for seriously mentally ill persons. The patients whom the Department of Mental Health is planning to care for are the most seriously mentally ill patients in the Commonwealth and will require a level of psychiatric and rehabilitation care that is not currently provided in any private or public mental health facility in Massachusetts.

V. IMPLEMENTATION

The proposals described above are the Department of Mental Health's programmatic recommendations to implement the Legislative mandate articulated in Section 5 of Chapter 1 of the Acts of 1988. Implementation of the proposals above is dependent on timely legislative and executive decisionmaking, drawing upon the expertise and cooperation of key branches and departments of the government. For example, staff from the Division of Capital Planning and Operations are currently investigating

construction possibilities for the new units. Staff expert in program development report that it will take at least three to six months to recruit, hire, and train professional, direct care, and security personnel to staff the new inpatient programs described in this report.

Furthermore, to effectively implement Section 5 of Chapter 1 of the Acts of 1988, legislation must be enacted which changes M.G.L. Chapter 123. The Department recommends that a comprehensive review of Chapter 123 be conducted under the auspices of the Governor's Special Advisory Panel on Forensic Mental Health that has been formed pursuant to the provisions of Section 4 of Chapter 1 of the Acts of 1988. This comprehensive review is needed to ensure that all aspects of the complex relationships between Bridgewater State Hospital and Department of Mental Health facilities are carefully considered and addressed. Pending this comprehensive review, the Department believes that the simplest way to accomplish the changes needed to implement Section 5 of Chapter 1 of the Acts of 1988 is to amend Chapter 123, s.1 by adding the following definition:

"Strict security" or "strict custody", the level of security and custody maintained by the department of correction in order to prevent escape from and maintain order in Bridgewater State Hospital, provided that no individual shall be determined by any person or in any proceeding authorized by this chapter to need strict security or strict custody unless (i) the individual is serving a criminal sentence or (ii) the individual has a criminal charge pending against him or (iii) the individual is awaiting sentencing or (iv) the individual has been found not guilty by reason of mental illness or mental defect or (v) the individual was first found to need strict security or strict custody pursuant to the provisions of sections fifteen, sixteen, or eighteen and thereafter has remained continuously under commitment to a facility providing strict security or strict custody.

A critical issue in changing the law would be when such an amendment would be effective. There are at least three options that should be considered:

- 1) Effective unconditionally as of March 31, 1989.
- 2) Effective unconditionally as of March 31, 1989, for all Section 13 transfers (i.e., movements from DMH to Bridgewater State Hospital); effective for all other purposes on such date as DMH completes the facility and program development work called for in its April 25, 1988 plan.
- 3) Effective for all purposes on such date as DMH completes the facility and program development work called for in its April 25, 1988 plan.

The implementation of any of the plans listed in the Recommendations section are dependent upon two critical variables: the construction of facilities that will meet the clinical and security needs of

this population and the allocation of, and timely access to, the necessary resources for the development of the needed levels of care.

To meet the timetables described in Chapter 1 of the Acts of 1988, the Department proposes the following implementation plan:

Beginning in July, 1988, the new DMH Resource Team will conduct a thorough psychiatric, medical, neuropsychiatric, rehabilitative, behavioral, and nursing evaluation of each of the patients at Bridgewater State Hospital who has been transferred there from a DMH facility. A short-term and a long-term individual treatment plan will be developed for each patient. Major goals of each plan will be to change the frequency, intensity, and duration of violent behavior; and to improve the patient's functional capacity in the following areas: communication, self care skills, level of meaningful activity, relationships, alternatives to violent behavior, and mental status.

The DMH will reduce Section 13 transfers gradually through the activities of the Resource Team and their role as special trainers for all inpatient units. They will work with facility heads and inpatient staff to create a capacity via the "Menu of Options" and the development of the behaviorally-difficult-to-manage beds to gradually reduce, and ultimately stop, all Section 13 transfers of non-criminally involved patients by March 31, 1989. This must occur in conjunction with the construction of the new special facilities that will enable the DMH to provide treatment to patients who experience episodes of acute violence.

The second component of the plan is to provide care and treatment for the DMH patients at Bridgewater State Hospital. If the proposed plans are endorsed, starting in Fall 1988, the DMH will begin to recruit and hire inpatient staff for the new facilities. The Resource Team will work with key new clinical staff to develop the clinical programs for each of the new facilities. The new secure facilities must be available for staff occupancy by January 1, 1989. A six week training program will begin in early 1989, for new staff who will provide care in these new treatment environments. Patients will begin to transition out of Bridgewater State Hospital in February, with all transfers planned to be completed by March 31, 1989.

This implementation plan is dependent on the critical variables stated earlier: adequate safe and secure facilities and the necessary resources outlined in this report.

Implementation Timelines

July 1, 1988: Funds and positions available for hiring Resource Team

October 1, 1988: Funds and positions available to begin hiring staff for new units

January 1, 1988: New units available for staff occupancy

January 15, 1989: Staff hired for new units; training begins

February 15, 1989: Patient transfers begin

March 31, 1989: Patient transfers completed
